NHS review

The government's white paper *Working for Patients* was published just as the *BMJ* was going to press. The proposals for the NHS subject the service to a full measure on the enterprise culture which has characterised the Thatcher years.

In a foreword the Prime Minister says that the proposals represent the most far reaching reform of the NHS in its 40 year history. The theme is to delegate more control to local hospitals and doctors in a way that carries forward vigorously the transition from an administered to a managed service.

Autonomous hospitals run by NHS trusts, general practitioners holding their own budgets for referrals, and wider use of medical audit are salient features of the white paper. There are consequent changes in methods of funding, including "indicative drug budgets" for general practitioners and overall budget control passing from the Department of Health to the Audit Commission.

Most hospitals with over 250 beds—320 in all—will be encouraged to become self governing, each under an NHS hospital trust, beginning in 1991. The aim is to encourage a stronger sense of local ownership and pride. They will be run by boards of up to 10 directors, and will enter into contracts to provide services for district health authorities, general practitioners, and private patients.

Guaranteed core services in the contracts will cover accident and emergency, immediate surgical and medical admissions, outpatients, and community services. Arrangements will ensure that patients who are in need of urgent treatment will not be turned away simply because their treatment is not covered by a contract.

Self governing hospitals will be free to employ and pay however many staff they wish, except for a limit on junior doctors, to dispose of assets, retain surpluses, and borrow funds.

Consultants will come under more local management, with districts agreeing a job description with each of them. Reform of distinction awards will require consultants to show not only clinical skills but also a commitment to the management and development of the NHS. New awards will be reviewable every five years and will not be pensionable for at least three years. Meanwhile, the government proposes to create 100 additional consultant posts above the 2% expansion already planned.

General practices with lists of 11 000 or more will be free to apply for their own NHS budgets for a defined range of hospital services—mainly outpatients, diagnostic tests, or treatment such as hip replacements and cataract removal.

The scheme will be voluntary, but the government believes that it will be attractive to the many general practitioners who are keen to improve the services they offer. It will give them scope to plough back savings into their practices.

Practices will be allowed to overspend by up to 5% a year, to be recouped the following year. Persistent overspending will initiate an audit and possible disqualification from the budget scheme.

All general practitioners, however, will be included in the new scheme of indicative drug budgets for each practice from 1991. This will not prevent patients getting the medicines they need, the white paper says, but will place downward pressure on drug spending. Practices exceeding their drug budget will be offered advice, and if they persist will be financially penalised.

The government also wants the profession to establish a system of medical audit in general practice.

At the top an NHS policy board will be chaired by the Secretary of State for Health, with operational matters under a management executive headed by the chief executive. In future regional and district health authorities will be reduced from their present 16 to 19 members to 10 and local authorities will no longer have a right to appoint members to district health authorities.

The RAWP funding formula will be replaced by a capitation system, and more cash will flow back to the Thames regions. Money required to treat patients will be able to cross administrative boundaries.

Closer cooperation with the private sector is envisaged, and private health care is seen as taking pressure off the NHS, and tax relief is planned on private medical insurance for pensioners.—JOHN WARDEN

MONITOR SYNDICATION

The Cabinet committee on the NHS review: from left to right, the Prime Minister, Kenneth Clarke (Secretary of State for Health), David Mellor (Minister of State for Health), John Major (Chief Secretary to the Treasury), Malcolm Rifkind (Secretary of State for Scotland), and Peter Walker (Secretary of State for Wales)

White or green papers?

A white paper is meant to denote the government's settled policy in advance of legislation, whereas a green paper is more tentative and subject to review. In recent times, however, the distinction between the two has become more blurred, with aspects of white papers open to discussion to such an extent that ministers talk about "a white paper with green edges." The NHS review has been published as a white paper. The recent proposed reforms of the legal profession were contained in a series of green papers. Official publicists are promoting these documents alike as showing the government's determination to break down the barriers of the legal and medical professions. In simpler times major government publications were confined to blue books, which were official reports, and white papers.

Kidneys for cash? London and Turkey

Non-NHS hospitals may soon have to provide the United Kingdom Transplant Service with details of all renal transplant operations that they perform. NHS hospitals already do: according to Mr Ross Taylor, president of the British Transplantation Society, government regulations will soon be introduced requiring non-NHS hospitals to follow suit—or lose their licence.

This follows allegations made by the *Independent* (18 January 1989) that two Turkish men were each paid £2000 to travel to London and donate a kidney for transplantation to a non-related recipient. In Turkey, where brokerage of human organs is a crime, police have arrested a man in connection with the allegations. Here, the Department of Health has ordered an immediate inquiry.

So far the hospital at the centre of the allegations, the Humana Hospital Wellington, has issued a press statement saying that the donors named in the newspaper article were admitted there in July and September last year by Dr Raymond Crockett, consultant physician nephrologist and medical director of the National Kidney Centre (a registered charity based in Finchley, north London). According to the hospital, "Both patients did not appear to be under any duress and willingly and freely signed a consent form for the operation to donate a kidney. The nursing staff did not detect any irregularities and an interpreter was present." A spokesman for the hospital said that it acted in good faith on the information supplied by Dr Crockett, who is aware of hospital policy that kidney donations may be made only by relatives of the recipient.

The allegations resemble those made in 1985 that paid donors were travelling to London from India and Pakistan. An inquiry was held, and although no new legislation was framed as a result, the Department of Health wrote to hospitals in the private sector warning them against the practice.

Responding to the recent allegations, Mr Roger Freeman, parliamentary under secretary for health, said that the government was totally opposed to payments for organ donation and that Britain was party to a Council of Europe resolution against the trade. He reminded the private sector of the department's 1985 letter, which made it "absolutely clear that my department condemned such practices as improper, undesirable, and unacceptable, and drew attention to statutory provisions for cancelling the registration of a hospital if its conduct was found to be improper, undesirable, or unacceptable in any way."

Bloomsbury Health Authority, within whose boundaries the Humana Hospital lies, is undertaking the investigation. A spokeswoman for the authority has confirmed that as before no one will be travelling abroad to investigate the claims. She did not know whether the findings of the investigation would be made public.

Since the 1985 allegations the British Transplantation Society has been working with the government on guidelines on renal transplantation. The events of recent weeks are certain to speed their implementation.—TONY DELAMOTHE

Kidneys for cash: India

As India has no legally accepted concept of brain death a person is deemed to be dead only when all vital functions have ceased. By then most organs are unsuitable for transplantation: in India cadaveric tissue transplantation is restricted to cornea, bone, dura, and skin.

Under these circumstances patients needing kidneys must turn to living donors. Reputable medical institutions carry out organ transplantation only when donors are relatives of recipients and offer the required organ as a free gift. Unfortunately this is not the practice of all transplant departments. When patients needing kidneys are willing to pay donors as much as £10 000 for a kidney quite a few people who live hand to mouth will willingly part with one. Poverty and need override other considerations. As yet neither the recipients of such organs nor the surgeons performing the operation have been prosecuted. It is estimated that 1000 kidney transplantations are performed in India each year, though about 100 000 such operations are needed.

Ethical transplant units, concerned about such practices, have increasingly made their voices heard. A drive towards legalised use of cadaveric transplants has been led by doctors in Bombay and has now gained followers in Madras, Chandigarh, and Delhi. The Transplant Society of India has been formed to pursue the twin goals of abolishing the trade in kidneys and making cadaveric organs freely available for transplantation throughout India. So far only seven transplant operations using kidneys from cadavers have been carried out here, one of these using a kidney imported from the United States.

The government has responded by setting up a working group to study the measures necessary for legal cadaveric transplantation. The matter has yet to be taken up in parliament despite many pleas over the past decade.—SUNIL K PANDYA, *professor of neurosurgery, Bombay*

France against AIDS

As the number of cases of AIDS in France approaches 5000 the often criticised public health policies on the disease are being reappraised.

The French government has decided to create a national agency to coordinate the struggle against the AIDS epidemic. The agency under the control of Claude Evin, Minister of Solidarity, Health, and Social Protection, and a national AIDS council, independent of political power, will be created as a moral authority representing various religious and philosophical trends in the country. The director of the agency and the members of the new bodies have not yet been selected.

The new bodies will, it is hoped, put an end to the political bickering and criticism that have surrounded public health policies on AIDS. Professor Claude Got, a well known public health specialist who previously denounced the lack of coherence of the measures taken against the spread of the epidemic, approved "without reservation" this latest government decision.

One of the first problems that the agency and the council may have to tackle concerns HIV screening. A recent public opinion poll showed that 70% of the public and about half of the country's doctors favour systematic and compulsory screening of the population. More than 90% of doctors favour systematic testing of only groups at risk (homosexual men, people with multiple sexual partners, and drug addicts). Suggestions that screening tests be made compulsory have been rejected on the advice of the National Ethics Committee, the Academy of Medicine, and the Conseil National de l'Ordre des Médecins. Systematic screening is performed only for blood, sperm, and organ donors, and doctors who think that testing is necessary in other cases thus find themselves in the unusual position of having to ask patients for their authorisation to request it. Many doctors admit that they request the test without their patients' knowledge.

The spread of AIDS has also prompted concern about the ability of the national health insurance scheme, the Sécurité Sociale, to bear the cost of treatment. The health ministry estimates the cost at 130 000-150 000 Frs (about £12 000-£13 500) per patient per year. Unless the epidemic levels off (as some epidemiologists believe will happen) or new and effective drugs are discovered the burden may become too heavy—the number of people with HIV antibody in France is estimated at 150 000-300 000.—ALEXANDER DOROZYNSKI, *Paris*

Cryptosporidiosis: another source

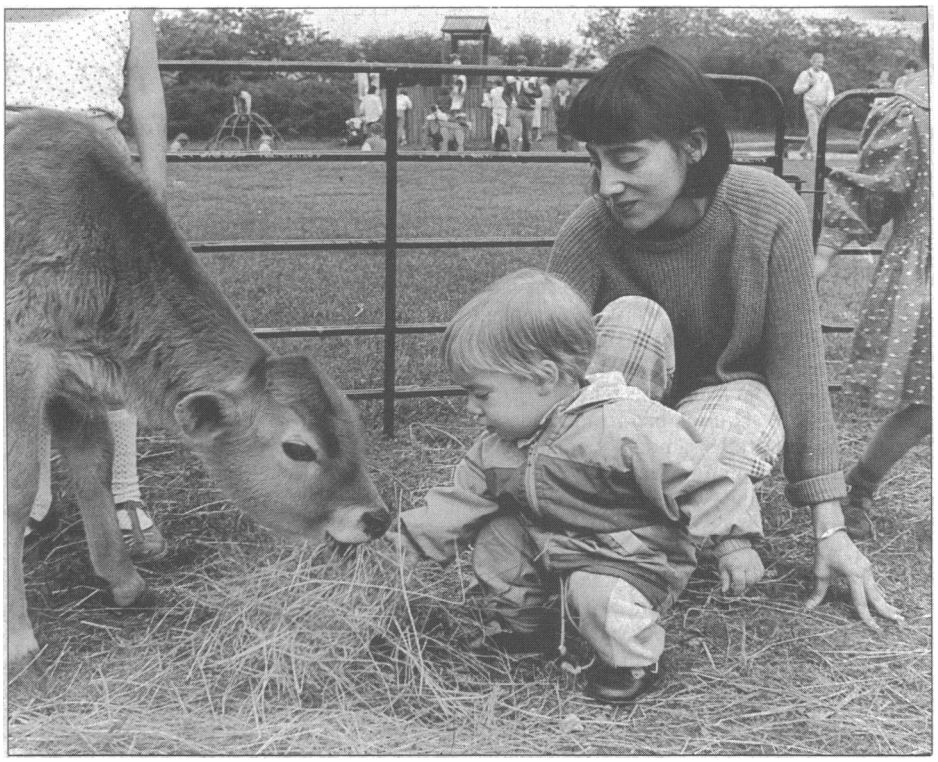
Most reported cases of cryptosporidiosis are sporadic and their source is not often elucidated. Cases have been associated with contact with domestic animals and pets—only recently the *Daily Telegraph* (this month) reported an outbreak in which four schoolchildren contracted the parasite during a visit to a farm in the west country. Some outbreaks have been associated with food, milk, and water, and spread by the faecal-oral route in families and nurseries seems to be common.

At the end of last year another outbreak was identified in the Doncaster area. Between June and November more than 70 cases of cryptosporidiosis were reported, about two thirds of them in children. In some the onset of the illness occurred after swimming in a local swimming pool for learners, and subsequently cryptosporidium was isolated from the water. On further investigation a defect in the drainage of the pool suggested the possibility of pollution by sewage.

Cryptosporidiosis is caused by a protozoan and was first recognised in mice at the beginning of this century but is now known to be a widespread infection in animals, and the organism is an important cause of diarrhoea in calves. Infection in humans was first reported in 1976, and the organism was later found to be a common cause of chronic, life threatening diarrhoea in immunocompromised patients, particularly those with AIDS. It was not until 1983, when improved techniques for detecting the oocysts in stools by stained faecal smears were introduced, that it was appreciated that cryptosporidiosis was also a common cause of self limiting diarrhoea in immunologically normal subjects, particularly children. About 300 infections in England and Wales are reported yearly to the PHLS Communicable Disease Surveillance Centre.

In immunocompetent patients the infection is usually denoted by the onset of anorexia and abdominal pain, sometimes suggesting appendicitis, after five to seven days' incubation. Diarrhoea with watery, foul smelling stools follows, persisting for about a week, and is often accompanied by vomiting, headache, and fever. In some cases the diarrhoea may continue, alternating with periods of constipation, for several weeks.

This episode in Doncaster may be unique, but the possibility that people have swum or participated in water sports in sewage polluted water should be considered when investigating future cases of cryptosporidiosis.—N S GALBRAITH, *Blackheath, London*



JOHN RAE

An enticing prospect for children of all ages, and washing hands afterwards—before eating or putting them in the mouth—reduces the possibility of infection with cryptosporidium. For others, swimming in sewage polluted water may present a bigger problem

Apothecaries reduce exams

In response to a recommendation from the General Medical Council the Society of Apothecaries is to reduce the number of times it sets its final examination from 11 to four times a year. The examination is taken by British medical graduates who have failed their university examinations and by graduates of overseas medical schools. There have been criticisms that the society offers a "back door into medicine," and one particular concern was that students could have many more attempts at the society's examination than at a university examination.

The GMC also recommended that the clinical part of the examination should take place in a hospital rather than in the Apothecaries' Hall. This recommendation is being followed, and the exam will be at St George's Hospital in London.

The society has set up a committee of governance to look at its examination. The committee includes representatives from medical schools and has taken a preliminary look at whether multiple choice questions should be included in the examination.

Some critics have questioned whether non-university licensing bodies are needed at all, but the GMC has not addressed this question.—RICHARD SMITH

Ethnic monitoring: how to do it

For years there have been allegations of racial discrimination in the health service, but many complaints have been based only on anecdotal evidence. Ethnic monitoring of employees provides an opportunity to prove or refute allegations such as "black nurses are overrepresented in the SEN grades and on night shifts" or "coloured doctors are seldom appointed by prestigious teaching hospitals."

Ethnic monitoring—recommended by institutions such as the Trades Union Congress, the Confederation of British Industry, and the Institute of Personnel Management—has already been introduced in the civil service. The health service—Britain's largest employer with nearly one million staff—is slow to adopt the system that is accepted as good management practice by many other major employers.

This last finding comes from a recent King's Fund study, which also showed that fewer than 15 health authorities were keeping sufficient data about the ethnic groups in their employment. Collecting information about numbers of job applicants and successful candidates in each grade of employment from different ethnic groups is not legally required. In 1983, however, the Commission for Racial Equality published a code of practice that was subsequently approved by parliament. The provisions of the code are admissible in industrial tribunal proceedings under the Race Relations Act, and any health authority in such a position would be criticised if it were not undertaking ethnic monitoring.

The King's Fund Equal Opportunities Task Force was set up in 1986 to help health authorities tackle racial discrimination. It has just published its third occasional paper—*Equal Opportunities Employment Policies in the NHS; Ethnic Monitoring*—which includes a step by step guide on how to set up a monitoring scheme. The task force can advise health authorities about setting up monitoring systems and interpreting data. Copies of the booklet (price £3) and further information can be obtained from 14 Palace Court, London W2 4HS, telephone 01 727 0581.

Europe Against Cancer Year

As smoking is the main cause of death from cancer in the European Community programmes aimed at its prevention have been given priority among the community wide initiatives chosen for Europe Against Cancer Year.

At its British launch the Prime Minister, Mrs Margaret Thatcher, announced a new campaign to halve the proportion of teenagers who smoke over the next four years. The campaign, costing £2 million a year, will be run jointly by the Department of Health and the Health Education Authority.

Quoting research showing that of 1000 young adults who smoke cigarettes regularly, six would be killed on the road and 250 would die prematurely from tobacco related diseases, Mrs Thatcher said that the message that smoking kills must be taken to young people. About 95% of those who die from lung cancer are smokers, she said, and for most the habit is acquired before adulthood. "Lung cancer deaths among women are increasing each year and teenage smoking by girls is still increasing—and both these trends we must strive to reverse."

Mrs Thatcher announced a full programme of events aimed at "breaking the silence" over cancer. The government is giving the Health Education Authority an extra £1 million to expand its cancer prevention and education programmes.

The Prime Minister pointed out that screening already played a major part in cancer prevention in the United Kingdom. "We can be really rather proud that we were the first in the community to have launched a comprehensive cervical screening programme and the first in the world to set up a nationwide breast screening programme."—TONY DELAMOTHE

"Smoking causes cancer" in Ireland but not Britain

The government's commitment to reduce smoking will not go as far as requiring tobacco companies to label cigarette packets with "Smoking Causes Cancer" or "Smokers Die Younger," as is done in the Republic of Ireland. At present the government is fighting a rearguard action against a directive from the European Community to include such warnings.

The elimination of all trade barriers within the community by 1992 requires the harmonisation of national provisions governing the labelling of tobacco products. Harmonisation must be with the most "healthy" national provision—in the case of tobacco labelling, the Irish laws.

Critics of the directive maintain that arguments about free trade obfuscate the main point of health warnings—that they are concerned with health. The distinction is crucial: directives with ramifications for the internal market may be passed on a majority vote, whereas directives on health grounds require unanimous agreement.

If the directive goes through Britain wants compliance with it to be voluntary rather than compulsory. This would mark a departure from established practice: it is assumed that directives will be incorporated into the laws of individual member states.

Arguments about "freedom," so often voiced in debates about antismoking legislation, have now been joined by ones about "national sovereignty."

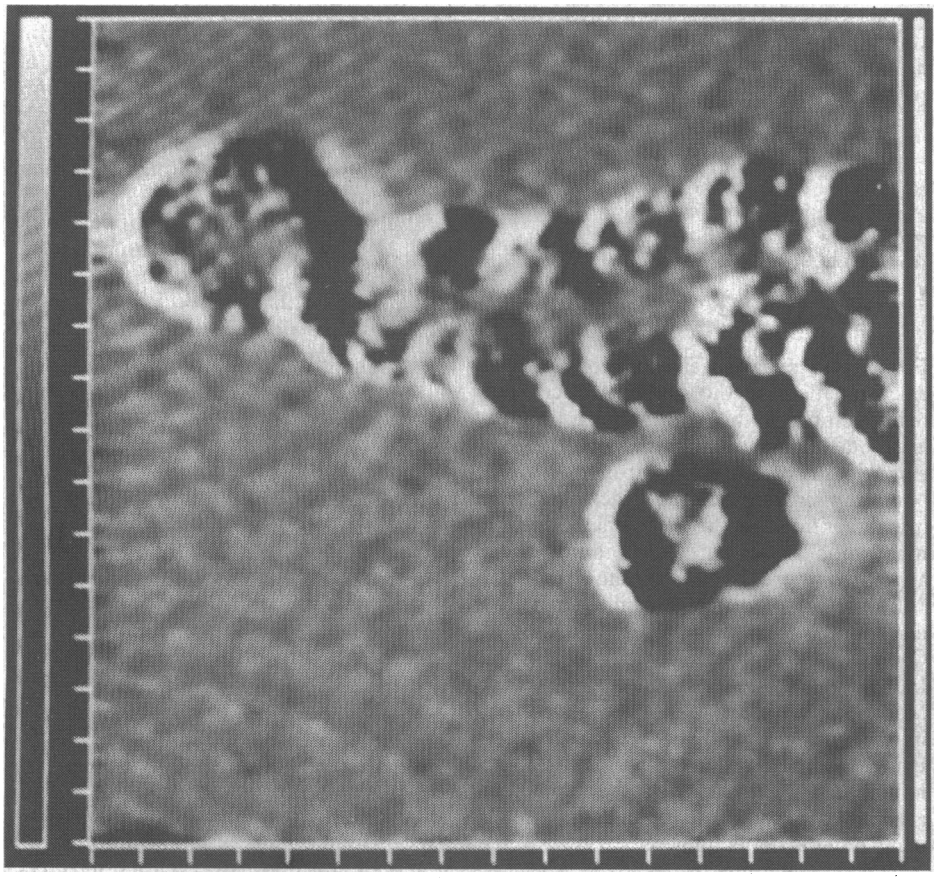


Image of calf thymus DNA obtained by scanning tunnelling microscopy covering an area 400×400 angstroms. The image shows the DNA duplex entering (top right), making a loop, and crossing over itself (top left). The isolated structure is probably a DNA fragment. Illustration reproduced by permission of technical information department, Lawrence Berkeley Laboratory, University of California

Images of native DNA

The image is that of the double helical structure of native DNA obtained with a scanning tunnelling microscope and represents the highly magnified surface contours of the atoms comprising the DNA molecule.

The microscope—designed by a team comprising a chemist, a biochemist, material scientists, a surface scientist, and a biophysicist at the Lawrence Livermore National Laboratory and the Lawrence Berkeley Laboratory in California—is a variation of the device for which Gerd Binnig and Heirich Rohrer of the IBM Research Laboratory in Switzerland were awarded the Nobel prize in physics in 1986. Its "eye" is a sharp tipped stylus of a platinum-rhodium alloy attached to a tube of piezoelectric ceramic that expands and contracts in response to an electrical charge. When the tip is brought to within a few angstroms above the surface of the sample a quantum mechanics phenomenon known as "tunnelling" results in a current of electrons crossing the gap, which makes the ceramic expand or contract. As the tip scans across a sample it moves up and down, and the motions are interpreted as a three dimensional image by computer.

The tunnelling process requires an electrically conductive surface, and the graphite is used as a substrate for the specimen as it is a chemically inert conductor that provides

atomically flat crystal planes over thousands of angstroms.

To obtain the image commercially available calf thymus DNA was mixed in a solution containing potassium chloride and a drop of the solution deposited on to the graphite. On evaporation of the liquid the native DNA remained, which was then scanned over an area not exceeding 0·5 by 0·5 μm, the maximum scanning range of the microscope.

Previous high resolution images of DNA—obtained with electron microscopes—do not show the native molecule as the material must be placed in high vacuum and coated or "shadowed" with a metal, usually a gold alloy, for the electrons to create an image.

The scientists in the United States are now trying to determine whether the four constituent nucleotides of DNA can be distinguished by the technique, and they even hope to obtain images of the structure of complex molecules such as proteins and to witness their interactions.

Letter from Westminster

Consultants hold the key to juniors' hours

The House of Lords stayed up late on Wednesday of last week to talk about the long hours worked by junior hospital doctors. The occasion was a debate on Lord Rea's private member's bill to limit junior doctors' availability for work to a weekly average of 72 hours by 1992, eventually reducing to 60.

The bill was given an unopposed second reading, though less by reason of any deep conviction in a legislative remedy than as a token gesture in support of something being done. The considered view of their lordships, however, was that cutting juniors' working hours was not primarily a case for action by the government or even parliament but essentially for the profession itself—and specifically for hospital consultants.

Junior doctors may reflect that their campaign has hit all the right targets. Its shock impact on the public made ministers jump and, in turn, exert pressure on the hospitals to reorganise their rotas. The lords' debate considerably reinforced this process even though it perhaps failed to chime in with the more impatient tones of the juniors.

This is hardly surprising given that the medical peers who spoke had an average age of over 70. There was no dispute that hospital doctors work excessive hours. It was also agreed that juniors' hours of duty had fallen in 10 years from 91 to 83 on average and actual hours of work from 59 to 57.

Lord Rea said that although junior doctors' total hours had been marginally cut, interrupted sleep while on call had greatly decreased, with consequent risk to the safety of patients and a collapse of morale in overworked doctors. He thought a 72 hour week by 1992 was realistic. It implied a one in four rota, though Lord Rea thought that it could still be achieved within the government's guideline of one in three with certain changes in working practice, like cross cover, flexible working, reorganising split sites, and a small increase in manpower. He also advocated consultant growth of 4% a year and extending hospital practice among general practitioners.

But the real mood of the upper house was caught by Lord Trafford, who is a working consultant. He thought that the problem could be solved almost within existing resources and without legislation. "It is the will, not the means, that is lacking," he said. "The real answer lies with consultants: they should look at their own working practices."

Lord Trafford chastised consultants who blithely swan in and out. Leadership of a team required attention to detail, such as organising rotas to avoid Friday to Monday weekends, which were asking for trouble. In his view the Department of Health might have put in more effort, but he understood its reluctance to get involved in what was primarily a professional matter.

"Blame the officers"

This view was echoed by Lord Winstanley: "The only people who can solve this are junior doctors and consultants. They should get on with the job." The Earl of Halsbury, veteran ex-chairman of the pay review body, was even more forthright: "Stick and carrot, my lords, stick and carrot," he advised. "No more merit awards where consultants and junior doctors don't get together to solve this problem. If the other ranks are demoralised blame the officers."

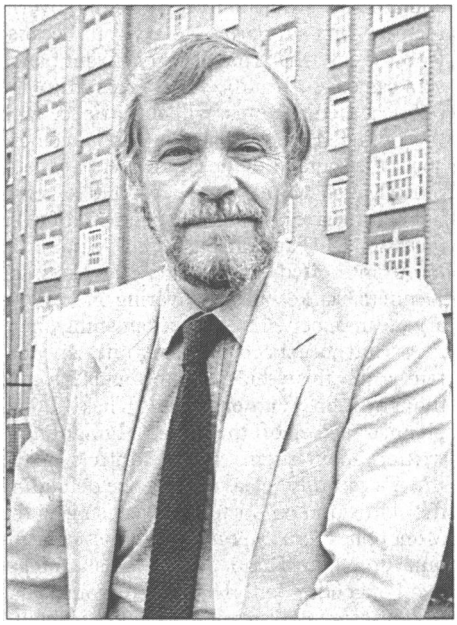
Lord Richardson was nostalgic for the house officer he was in the 1920s, when there was a sense of adventure about the job. "Patients know when a doctor is dedicated. That is the way to happiness in medicine." Lord Richardson described regulating hours by legislation as profoundly against the basic professional ethos. The hallmark of a profession was that it controlled its education, discipline, and responsibilities.

But Lord Pitt supported the bill, and Lord Porritt admitted to having changed his mind in favour of limiting hours because of the dramatic change in the face of medicine during the past 40 years. The Bishop of Southwark focused on training and how long hours of work reduced the capacity to learn. There should be time for taking in as well as giving out, and he said that many junior doctors felt unsupported by their senior colleagues.

It all left the government's duty spokesman, Lord Hesketh, with little of substance to add except that the government was committed to seeing a further reduction in juniors' hours—but not by means of legislation.

Surgical deaths from fatigue

Some support of the junior doctors' plight is being based on the 1986 confidential inquiry into perioperative deaths (CEPOD). This attributed 28 avoidable deaths, out of 618, to the surgeon's fatigue. The results can be extrapolated to represent 140 patients a year dying as a result of fatigue—though that presumably includes consultants as well as their juniors.



KEITH MORRIS

Lord Rea

With the much more extensive CEPOD II taking place this year, the Department of Health is at pains to reassure MPs against overreacting to the findings. In a memo to the House of Commons public accounts committee the department says that the 1986 study found that death within 30 days of operation was a rare outcome. The mortality in over half a million operations was 0·7% and most of these deaths were in the elderly. Death was solely attributable to "avoidable" surgical or anaesthetic factors in a very small proportion of operations.

Moreover, the assessors' views were reached in hindsight, while the actual decisions on the patient's treatment were often made under the pressure of an emergency admission. The department's document says CEPOD is unique in the world because both surgery and anaesthesia were subjected to a vigorous form of peer review. It has highlighted areas of medical practice where improvements need to be made, enabling the medical profession to question established procedures and to improve standards of care.—JOHN WARDEN

Labour steals a march on NHS review

". . . The medium is the message." When Marshall McLuhan coined that phrase in his book *Understanding Media* in 1964 Harold Wilson had just become prime minister. In his years at number 10 Downing Street Mr Wilson exploited the phrase to the full. Twenty five years on manipulation of the media by Whitehall is as much a part of daily life as television advertising, personal stereos, and pressure group politics. So for the government and its supporters to cry foul because Robin Cook, the Labour party's front bench spokesman on health, stole a march in the political media contest will cut little ice with the public. His pre-emptive announcement about the contents of the government's already much leaked white paper on its NHS review is unlikely to have bothered the passengers on the (occasional) Clapham bus. They will be far more interested in whether the message Kenneth Clarke will be delivering on 31 January means a better NHS or a vanishing one.

As I did not expect to see the white paper before writing this week's column—and I haven't, though John Warden (p 275) has—I had planned to keep off the subject. I might have written about such riveting subjects as the BMA's recently released evidence defending the status quo on doctors' advertising to the Monopolies and Mergers Commission's inquiry, or about Kenneth Clarke's announcement of goodies for NHS staff (discount holiday and car rental rates, for example), or about a learned monograph, *Efficiency in the National Health Service*, from Birmingham University's health services management centre—a one sentence summary of which is that the NHS can release cash by greater efficiency (surprise me).

My mind has been changed by the Secretary of State's indignantly defensive response to Robin Cook's revelations and corroborative comment on these in the Sunday press. Robin Cook obviously got it right. Did I hear someone say "get on with it"? I will, starting with the dogmatic observation that three strands in the government's proposals are easily identified:

- To provide people with a greater choice of better health services
- To contain public spending on health care while attracting new funds from elsewhere
- To streamline the NHS's bureaucracy, strengthen its management, and devolve power to local services.

I also identify other less overt strands:

- To lay the groundwork for future privatisation of the service
- To introduce cash limits into general practice
- To cut the power of doctors.

All of these are legitimate political objectives whether or not you agree with them. So before reflexly rejecting the government's plans as leading to the destruction of the NHS as we have known it and that we have (more or less) cherished doctors would be wise to study the proposals with care and map their responses with equal care. Kenneth Clarke is a tough politician—"the thinking man's lager lout" was how the *Independent* recently described him—who is a skilled public communicator. I imagine that the BMA's initial tactics will be to welcome those proposals that it judges will improve the care of patients, to criticise those that will not, and to keep its powder dry about intended changes in doctors' conditions of service.

Meanwhile, if it is sensible—and who am I to suggest that the association is anything but that?—its strategy should be to plan a country-wide campaign using local doctors as well as national representatives to bring the profession's views to the public and parliament. I believe that the government has set an unrealistic timetable for its changes—for a start the NHS information services are not up to coping with the rapid change—but even that timetable of legislation in the next parliamentary session and implementation started in 1991 leaves time for the profession to mount a campaign to ensure that the principles of the NHS are genuinely preserved.

Minister rejects accusation of privatisation

Kenneth Clarke has vociferously protested his belief in the NHS, rejecting the opposition's claims that this review is the first stage in the privatisation of health care. I would like to believe him, but the origins of and input into the review suggest otherwise. The financial crisis that provoked Mrs Thatcher to set it up was seen by her more ideological supporters as an opportunity to move the service away from the public sector. The orchestrated barrage of papers and evidence from radical conservative think tanks, etc, and the secrecy surrounding the review itself all suggested that the fundamental tenets of the 1948 NHS were under threat, though many commentators, including myself, hoped and even forecast otherwise.

In the event no radical alternative options have been offered for financing the service—ironic really when the initial stimulus for the review was a lack of money. Instead we have a halfway house concept of certain general practices, covering about a quarter of the population, being allowed (if they wish) to run purchasing budgets for obtaining care for their patients and of over 300 hospitals being eligible to become independent trusts selling their services to health authorities. This strikes me as a messy compromise between radicals and pragmatists. Despite safeguards for certain core services it could result in widely varying availability of hospital services round the country, with teaching hospitals possibly regressing to something like their pre-1948 status, and the distinct risk of some patients getting cut price general practice care towards the end of the financial year.

I am not convinced that these two ideas will attract new money, save much existing money, improve the choice for patients, or enhance the efficiency of the service. For example, if general practitioners are cash limited but allowed to keep part of any budget surplus I can foresee the elderly and chronic sick being limited to smaller practices outside the budget holding scheme. Furthermore, there is no sign—at least not that I have divined among the leaks—of the government introducing genuine pilot schemes for evaluating the proposals before they are widely introduced. The NHS has suffered grievously during the past 15 years from ill thought out reforms hastily imposed. I doubt that it can survive another.

Dangerous gap in community care

Let me continue this damp and discursive trip round the white paper leaks by pointing out that unless the official version contains a last minute remedy there is a dangerous gap in it. The government has failed to tackle the shortcomings of community care in tandem with those of the hospital and general practitioner services. A major weakness of the health services since 1948, and one identified nearly 30 years ago by Sir (now Lord) Porritt's BMA initiated NHS review, has been their tripartite structure. Although this 1989 review edges towards pulling general and hospital practice together by streamlining family practitioner committees and relating them to health authorities, an opportunity will have been wasted if community services are not linked more effectively with the two other sectors.

Sir Roy Griffiths reported on the subject 11 months ago, proposing a local authority led coordination of community services, yet the government remains silent. Demographic changes in the population and the policy of moving the mentally ill and handicapped from institutional to community care should have persuaded the government to include the community sector. Is it ducking the problem because of the Prime Minister's well known anathema to local authorities? Whatever the reason, ministers should think again.

Finally, much has been said about health care in the United States, in particular the American health maintenance organisations, being used as a guide for these reforms. Although they were published too late to influence the Prime Minister's review, I hope that she and her colleagues will none the less read two recent issues of the *New England Journal of Medicine* (5 and 12 January). They contain some devastating critiques of the present position across the Atlantic by Professor Alain Enthoven and others. They also offer some thoughtful solutions that if anything shift away from the free market health care favoured by Britain's radical right. The five articles are hard going but deserve attention in a Britain that is, I believe, in danger of taking the wrong course in providing health care.

SCRUTATOR